Contra Costa County Open Enrollment Change Form for Plan Year January 1, 2015 - December 31, 2015

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AREA 1 - PERSONAL INFORMATION

Name(Last)	(First)	(MI)	SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐	EMPLOYEE NUMBER
ADDRESS				DATE OF BIRTH
CITY	STATE	ZIP	DATE OF HIRE OR RETIREMENT / BUC	HOME PHONE NUMBER
WORK DEPARTMENT			WORK PHONE NUMBER	☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ DOMESTIC PARTNER

WORK STATUS:
☐ PERMANENT FULL-TIME ☐ PERMANENT INTERMITTENT ☐ PERMANENT PART-TIME AT _____ HRS.PER WEEK
☐ PROVISIONAL ☐ RETIREE ☐ RETIREE SURVIVOR ☐ COBRA

AREA 2 - SELECT COVERAGE

Active Employees and Non Medicare Eligible Retirees		Medicare Eligible Retirees	
EMPLOYEE ONLY	EMPLOYEE AND FAMILY	EMPLOYEE ONLY	EMPLOYEE AND FAMILY
CCHP A ☐	☐	CCHP A Coordination of Benefits (COB) ☐	☐
CCHP B ☐	☐	CCHP B Coordination of Benefits (COB) ☐	☐
Health Net HMO A ☐	☐	Health Net Coordination of Benefits (COB) ☐	☐
Health Net HMO B ☐	☐	Health Net PPO A ☐	☐
Health Net PPO A ☐	☐	Health Net PPO B ☐	☐
Health Net PPO B ☐	☐	Health Net Seniority Plus A* ☐	☐
Kaiser A ☐	☐	Health Net Seniority Plus B* ☐	☐
Kaiser B ☐	☐	Kaiser Senior Advantage A* ☐	☐
Coverage Waived for Employee / Retiree and Family ☐		Kaiser Senior Advantage B* ☐	☐
No Changes ☐		Coverage Waived for Retiree and Family ☐	
		No Changes ☐	
		* An additional enrollment form is required to enroll in this plan.	

Is your spouse/domestic partner a current employee or retiree of Contra Costa County or special district? ☐ Yes ☐ No
If Yes, please provide their employee number: _____

AREA 3 - MEDICAL ENROLLEE REQUIRED INFORMATION

For Office Use Only ⇨ Group #: Effective Date: PCP: ☐ Yes ☐ No

A = ADD D = DELETE	LAST NAME, FIRST NAME, M.I.	DATE OF BIRTH	SEX M/F	RELATION TO YOU	SOC. SEC. NUMBER	PRIMARY CARE PHYSICIAN
	1			EMPLOYEE		
	2			SPOUSE		
	3					
	4					
	5					
	6					

EMPLOYEE NAME:	
EMPLOYEE NUMBER:	

AREA 4 - SELECT COVERAGE		
DENTAL		
	EMPLOYEE ONLY	EMPLOYEE AND FAMILY
DELTA DENTAL	❑	❑
PMI DELTACARE	❑	❑
Coverage Waived for Employee / Retiree and Family		❑
No Changes		❑

AREA 5 - DENTAL ENROLLEE REQUIRED INFORMATION For Office Use Only ⇨					Group # Effective Date: PCP: ❑ Yes ❑ No	
A = ADD D = DELETE	LAST NAME, FIRST NAME, M.I.	DATE OF BIRTH	SEX M/F	RELATION TO YOU	SOC. SEC. NUMBER	PMI PROVIDER NUMBER
	1			EMPLOYEE		
	2			SPOUSE		
	3					
	4					
	5					
	6					

I have read and completed the information in area 1 through 5 on pages 1 & 2

I have read the information on page 3 related to Dependent Eligibility Documentation.

I have read the information on page 4 related to TERMS & CONDITIONS.

I authorize the Contra Costa County Auditor-Controller or CCCERA to deduct from my monthly salary or pension benefit any premium payments due as my contribution for the plans in which I have elected to participate. Further, I understand that if my check is not large enough for full premium payment, the payment will not be deducted and that it is my responsibility to make that payment directly to the Contra Costa County Auditor-Controller's Office by the 10th of each month of coverage. Failure to do so can result in the cancellation of elected coverage.

My signature certifies that I have reviewed and I understand the terms and conditions of electing to participate in the medical and/or dental benefits plans. Furthermore, all persons listed as dependents meet the definitions of dependent as stated on page 4 of this form, sections 8, 9 and 10.

EMPLOYEE/RETIREE/SURVIVING SPOUSE SIGNATURE	DATE SIGNED

Completed forms must be received by the Contra Costa County Human Resources Department, Employee Benefits Services Unit on or before **5:00pm, October 10, 2014 at 651 Pine Street, Fifth Floor, Martinez, CA 94553.** Remember, original Dependent Eligibility Documentation is to be included with the Enrollment Form.

Dependent Eligibility Documentation

Dependent's Relationship to Employee/Retiree	Certified Copies of the following document(s) are required
Spouse	State/County Certified Document of Marriage
Natural Child	Birth Certificate issued by the State, County or Country of birth.
Stepchild	Birth Certificate issued by the State, County or Country of birth, Marriage Certificate.
Foster Child	Birth Certificate issued by the State, County or Country of birth and Placement order or decree issued by a court.
Legally Adopted Child	Birth Certificate issued by the State, County or Country of birth and Decree of adoption or adoption order issued by court.
Child in Employee's Custody	Birth Certificate issued by the State, County or Country of birth and Pre-adoption order or initial placement order issued by court, tribal council, or tribal court.
Legal Guardianship	Birth Certificate issued by the State, County or Country of birth and Guardianship order or plan issued by court.
Foreign Adoption	Birth Certificate issued by the State, County or Country of birth, Foreign adoption approval by the United States Immigration Service Department and legal adoption documentation from country of adoption, or legal adoption documentation by the United States. If not final, member must have physical custody and adoption proceedings underway.
Tribal Adoption	Birth Certificate and Resolution from the tribal council (a certificate of recognition or letter of support for the adoption that identifies the biological and adoptive parents) or tribal court documentation, if the adoption was finalized by the tribal court.
Disabled Adult Child	In addition to required documentation as stated above you will be required to provide a disabled dependent certification from the chosen County Group Health Carrier.
Domestic Partner	Affidavit and required documentation as listed on the affidavit.
Child of Domestic Partner	Birth Certificate issued by the State, County or County of birth , Domestic Partner Affidavit.

1. Birth Certificates issued by a hospital are not acceptable as permanent documentation but may be used until the State or County certificate is available.

2. Birth Certificate must include either the employee/retiree's name, Spouse's name or Domestic Partner's name.

3. All documentation issued by a foreign country must be accompanied by a certified translation.

4. Dependent eligibility verification is required at new enrollment and annual recertification.

5. Please contact the Human Resources Department, Employee Benefits Services Unit at (925) 335-1746 for further clarification on required documentation.

TERMS & CONDITIONS
MEDICAL AND DENTAL ENROLLMENT FORM

Your signature on the front of this form constitutes your authorization to deduct from your paycheck or pension benefit check the amount of your monthly premium, and, indicates you have read and understand the following terms, conditions and provisions:

1. The Employee Benefits Services Unit will enroll you and your eligible dependents in the health and/or dental plan you have elected and in which you are eligible to participate.
2. Application to add eligible dependents to your coverage after this open enrollment can only be done in accordance with the provisions of the IRC, Section 125 as it relates to qualifying status change events, or, during the next open enrollment period.
3. It is against County Policy for an employee to enroll ineligible persons as dependents; to do so may subject the employee to disciplinary action as well as the obligation to reimburse the plan for all costs associated with the delivery of medical or dental care services to an ineligible person. Please see the list of required documents needed to enroll a spouse/domestic partner and/or a dependent child. Failure to provide these documents will result in no coverage.
4. Contra Costa County Medical and Dental Benefit Plans are in accordance with the governing Management Resolution or Memorandas of Understanding. Federal Law requires employees and their eligible covered dependents be given the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan.
5. The non-payment of any premiums results in termination of coverage for you and your eligible dependents. If you are unable to make a payroll or pension check deduction, all premiums must be made by check payable to and received in the Contra Cost County Auditor-Controller's office by the 10th of the month in which the payment is due.
6. If the plan service agreement of the health and/or dental plan you have selected contains a binding arbitration clause, you understand as part of your membership any monetary claim asserted by you or your eligible dependents, heirs or personal representative, on account of bodily injury, mental disturbance, death or any other issue, must be submitted to binding arbitration instead of a court trial. Refer to your plan booklets to determine if this provision is applicable to your plans.
7. You must authorize any person or hospital who has rendered medical/dental services to you or to any dependents covered by this application to make available to the health/dental plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the health/dental plan. Such information may also be released to persons or entities which in conjunction with or at the direction of the health/dental plan are conducting a review of cost, quality and/or appropriateness of services rendered. You also agree to complete and submit to the health/dental plan any necessary forms, consents, releases, assignments, application, questionnaires and other documents that the plan may reasonably request, and that you will authorize the release of information contained on this form to the applicable plan(s) and that all information so supplied is true, correct and complete.
8. Dependent Eligibility – Health Insurance only for employees, Non - Medicare eligible retirees and retiree survivors

   The following dependents of an enrolled employee, Non-Medicare eligible retiree and retiree survivor are eligible for health insurance:

   - Legal Spouse (Survivors may not enroll a spouse)
   - Qualified domestic partner (requires the completing and submitting of certification forms)
   - Child to age 26
   - Disabled child beyond age 26 who is unmarried, incapable of sustaining employment due to a physical or mental handicap that existed prior to the child's attainment of age 19. The disabled adult dependent must meet the disabled dependent requirements as defined by the health insurance carrier.
9. Dependent Eligibility – Health Insurance only for Medicare eligible retirees and retiree survivors

   The following dependents of an enrolled Medicare eligible retiree and retiree survivor are eligible for health insurance:

   - Legal Spouse (Survivors may not enroll a spouse)
   - Qualified domestic partner (requires the completing and submitting certification forms)
   - Unmarried children who are dependent on you, your spouse or qualified domestic partner for support who are
     - ✓ Under age 19;
     - ✓ Age 19 up to age 24, who are full-time students, dependent upon you for at least 50% of their support, unmarried and living with you.
     - ✓ Disabled child who is over age 19, unmarried, incapable of sustaining employment due to a physical or mental handicap that existed prior to the child's attainment of age 19 and is your dependent as defined by the Internal Revenue Service
10. Dependent Eligibility – Dental Insurance only for employees, retirees and retiree survivors.

    The following dependents of an enrolled employee eligible retiree and retiree survivor are eligible for dental insurance:

    - Legal Spouse (Survivors may not enroll a spouse)
    - Qualified domestic partner (requires the completing and submitting certification forms)
    - Unmarried children who are dependent on you, your spouse or qualified domestic partner for support who are
      - ✓ Under age 19;
      - ✓ Age 19 up to age 24, who are full-time students, dependent upon you for at least 50% of their support, unmarried and living with you.
      - ✓ Disabled child who is over age 19, unmarried, incapable of sustaining employment due to a physical or mental handicap that existed prior to the child's attainment of age 19 and is your dependent as defined by the Internal Revenue Service.
11. The definition of dependent child includes natural child, step-child, adopted child, child of a qualified domestic partner and any child specified in a Qualified Medical Child Support Order or similar court approved or mandated document.